PART I

GOALS AND WORKING PRINCIPLES

ONE

Introduction

I do not believe in a fate that falls on men however they act; but I do believe in a fate that falls on them unless they act.

G. K. Chesterton, English author (1874–1936)

Summary: *Many despair of solving the health care crisis in America, currently defined by the presence of large numbers of uninsured, large numbers of indigent and other limited-pay and no-pay users, rising costs, questionable quality, and budgetary challenges exacerbated by an aging baby boom generation. The problems are real, but the despair is unfounded.*

Working from the requirements that Americans say they want their health care system to satisfy and applying economic principles to meet these stated objectives identify a unique framework within which options for implementation can be selected. The key to a self-sustaining program is respecting the relevant principles and intervening at the minimal set of system points required to accomplish the objectives.

There is growing recognition that the time is at hand for serious action on American health care policy. Even though 8 out of 10 Americans are happy with their own medical care experiences,[1] approximately the same percentage are concerned that the U.S. health care system is not functioning as it should for others and requires serious attention. At the time of writing, the Census Bureau estimates that 15.8 percent of Americans are without health insurance at any point.[2] Because almost 60 percent of all uninsured were employed in full-time or part-time jobs, it is a fair approximation to say that over 75 percent of the uninsured have some labor force connection – through their own employment or that of a family member.

While the public hopes that its leaders will take prudent steps to overhaul the system, they fear that bad decisions, partial measures, and political

[1] Blendon, et al., 2006.

[2] Out of a total population of 297.437 million, 46,995 million were reported to be uninsured at some point during the year. See U.S. Census Bureau, 2007.

agendas might make matters worse. In addition to the problems themselves, the planning failures of the early 1990s are still on the minds of many. Government is engaged with many problems, of which health care is only one. Most legislators know that the solution to health care cannot be the creation of an unending, untenable, and unsustainable budgetary burden: the public purse cannot solve the problem of health care; health care must solve the problem of the public purse. There is need for guidance and a workable course of action. Health care providers, the public, and government need to find consensus in a framework that is sustainable and implementable.

We have been taught that solving the health care problem in the United States is difficult. It is not. Health care issues are neither complicated nor, on the whole, hard to understand. It is possible to guarantee that everyone's health is insured with good coverage, provided in a sustainable way that reduces costs relative to the present, does not require large government budget participation, and imposes minimal limitations on the freedom of choice – for consumers and providers alike – without needing particularly vast sums of money.

The first step to finding the most desirable framework for activity is to identify the specific goals we want achieved, understand why collective action is needed, identify the agent of action (some or all of markets, voluntary private organizations, or government), and establish a road map to the desired destination. Packing for the journey will follow after we know where we are going.

The foundational assumption of this book, and of our work as economists, is that people know what is in their own best interest. This is not a statement of faith about perfect omniscience, but rather the understanding that the large majority of people, most of the time, know best what they want, and for virtually all those who do not, that circumstance is temporary. This suggests that while many people have dwelled on various aspects of the health care system as the source of our problems – employer-provided insurance that causes holders to lose coverage at just the time they may be losing their jobs comes to mind – we should cut away from secondary issues and go to the heart of the matter: *many people have no health insurance, and some of them truly cannot afford it.* The first is an insurance problem and the second is an income problem. Those who confuse the two run the risk of solving neither, or at best solving neither well. Our goal is to create incentives that will induce everyone to purchase insurance, will enable that purchase for those who truly need enabling, and will not provide aid to anyone else. Solutions to the two problems should not be inappropriately comingled.

We view the Targeted Intervention Plan (TIP) as a framework. As with the steel frame of a skyscraper, once a framework is erected that is compatible with the type of building being constructed, finishing choices can be made to suit the preferences of the users. As noted in the Preface, the intellectual content of the TIP owes much to the work of others. From them we have learned why there are a right way and many wrong ways to implement collective action in health care. In the remainder of this chapter we summarize the dimensions of the problem. Our message is an optimistic one.

Insurance status varies greatly by groups as shown in Table 1.1. For example, almost 30 percent of all 18- to 24-year-olds are uninsured, along with almost 27 percent of the 25- to 34-year-olds. Among native-born whites (non-Hispanic) the percentage is only 10.8. In contrast, 34.1 percent of

Table 1.1. *Individuals without Health Insurance by Characteristics, 2006*

Group	Uninsured (000)	Percentage of group that is uninsured	Group uninsured as percentage of total
All persons	46,995	15.8	100.0
Nativity			
Not a citizen	10,231	45.0	21.8
Naturalized citizen	2,384	16.4	5.1
Native citizen	34,380	13.2	73.2
Race			
Hispanic origin	15,296	34.1	32.5
Black	7,652	20.5	16.3
Asian and Pacific Islander	2,045	15.5	4.4
White, Non-Hispanic	21,162	10.8	45.0
Age			
Under 18 years	8,661	11.7	18.4
18 to 24 years	8,323	29.3	17.7
25 to 34 years	10,713	26.9	22.8
35 to 44 years	8,018	18.8	17.1
45 to 64 years	10,738	14.2	22.8
65 years and over	541	1.5	1.2
Income			
Less than $25,000	13,933	24.9	29.6
$25,000 to $49,999	15,319	21.1	32.6
$50,000 to $74,999	8,459	14.4	18.0
Over $75,000	9,283	8.5	19.8

Source: U.S. Census Bureau, 2006.

those of Hispanic origin have no insurance. Among non-citizen Hispanics the uninsured level is even higher, at 45.0 percent. And almost two-thirds of all illegal immigrants lack health insurance.[3] Finally, it is not accurate to assume that only the poor are uninsured. Almost 38 percent of the total uninsured have household incomes that exceed $50,000 per year.

In truth, the number of uninsured may be significantly smaller than 47 million, perhaps less than half that number,[4] depending on which survey and data source you use. Regardless, the precise numbers change from year to year, and our purpose is to show what they imply. We intentionally have rounded up some of the numbers, addressing the worst case to be on the safe side in presenting our optimistic message.

The most persistent finding in studies of the composition of the uninsured population is that its membership is constantly changing. Those uninsured today are not the same group that was uninsured last year. Being uninsured is a temporary phenomenon for most people. Robert Bennefield estimated that one-half of all spells without insurance last less than 5.3 months.[5] Similarly, Craig Copeland estimated that approximately two-thirds of the uninsured population are re-insured within less than one year.[6] But while being without insurance is a temporary phenomenon for most, there is a persistent group that remains chronically uninsured.[7]

Uninsured individuals nevertheless use health care resources, though they use fewer resources than individuals with full coverage use. The average uninsured spends on health care roughly half of what the average American spends. For example, one reason the uninsured, as a group, tend to use less health care is that they include a larger proportion of younger people than the population at large. Approximately 14.5 percent of American gross domestic product (GDP) is devoted to *personal* health care expenditures that would be expected to rise were uninsured individuals to become insured.[8] Were uninsured individuals to become insured, their use

[3] Derose, Escarce, and Lurie, 2007.
[4] The number of uninsured may be 21–31 million rather than the higher numbers often reported. See Congressional Budget Office, 2003.
[5] Bennefield, 1998.
[6] Copeland, 1998.
[7] Short and Graefe, 2003, estimated that this group numbers approximately 10 million, or about 3 percent of the U.S. population.
[8] In 2004 total personal health care expenditures were $1,696.896 billion, or 14.521 percent of GDP (GDP = $11,685.9 billion, Table B-1, *Economic Report of the President,* February 2008). Including expenditures for research, structures and equipment, and public health activity, which are not personal expenditures, raises the total to $1,877.622 billion, or 16.07 percent of GDP ("National Health Expenditures," in *Health Guide USA*, http://healthguideusa.org/NationalCosts.htm).

of health care resources would rise by approximately one-half.[9] As a percentage of income, the extra cost of full insurance coverage to the nation – what we call in this book T, the "top-off cost" – is therefore less than $0.0058 \times GDP$, or 58 one-hundredths of 1 percent of GDP.[10] This calculation is consistent with increased usage of medical care by each uninsured person of 25 percent of typical full usage.[11] Even if the figure 0.58 percent is imperfect, adjusting it to the extreme limit in which usage would rise by 50 percent of typical usage means that T is barely more than 1 percent (1.16 percent) of income.

What does this mean for extending coverage? First, not all of this amount would have to be provided by public dollars, because many uninsured can afford to pay for their own coverage. Some uninsured are temporarily between jobs and can afford transition coverage. Others in transition do not know that they are effectively covered by medical insurance for two months[12] and mistakenly report that they are uninsured during this period. Many uninsured earn incomes above $75,000 annually. Kate Bundorf and Mark Pauly conclude after careful consideration that at least 28 percent, and perhaps as many as 71 percent, of the uninsured can afford coverage.[13]

Treat Disease, Not Symptoms. Sometimes when a system fails at one point, everything else about it appears to need attention. Scarlet fever is caused by the Group A Streptococcus bacterium. It often is accompanied in an infected child by a reddened sore throat, fever above 101 degrees

[9] Marquis and Long, 1994/95, estimate that the uninsured increase their health care spending by 50 percent when they get insurance. Estimates of one-third have also been reported. In the most recent study of which we are aware at time of publication, Hadley, Holahan, Coughlin, and Miller, 2008, Exhibit 5, simulate increases of 38.4 percent and 117.6 percent for part-year uninsured and full-year uninsured. Since the uninsured consist of both groups, their figure for increased spending would be 69.9 percent.

[10] $0.5 \times 0.5[(\textit{Health expenditure}/\textit{Uninsured capita})/(\textit{Health expenditure}/\textit{Capita})] \times 0.16\,[\textit{Uninsured capita}/\textit{Capita}] \times 0.14521\,\textit{GDP} = 0.0058\,\textit{GDP}$

[11] $0.5 \times 0.5 = 0.25$ in footnote 10.

[12] The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 provides that an ex-employee may pay the former employer the cost of insurance and stay on the company's medical insurance plan. The election is made within 60 days of job termination by delivering the appropriate payment for insurance to the employer. Various provisions of COBRA effectively extend this period to two months with retroactive election, even when medical events have occurred within 60 days after employment.

[13] Bundorf and Pauly, 2006.

Fahrenheit (38.3 degrees Celsius), swollen glands in the neck, chills, body aches, loss of appetite, nausea, and vomiting. Tonsils and the back of the throat may be covered with a whitish coating, and the tongue may have a whitish or yellowish coating that later in the infection turns red, when its surface begins to peel. In fact, all symptoms will disappear when the root cause bacterium is killed – a simple process using modern antibiotics.

Second, making corrections to other aspects of the health care market– "rationalizing" the market – has the potential to produce savings approaching 2 percent of national income.[14] Economists would classify these as "moral hazard" gains (see the Glossary and Definitions and Chapter 7, "Insurance"). Market rationalization will also lead to lower-cost health insurance for many of those now uninsured. If the market is rationalized at the same time changes are made so that everyone is covered by insurance, the change in total spending on health care to the nation can be zero or negative.

The modest top-off costs perhaps explain a certain disappointment that many show about the failure to take action regarding health care insurance coverage. On the other hand, it is easy (and tempting) to write shortsighted legislation that instead of providing only essential – usually temporary and partial – aid to a fraction of the population offers inessential permanent full coverage to nearly everyone. This, of course, is not providing top-off costs, but much more.

Figure 1.1 graphically displays the health care market. The horizontal axis measures the size of the insured and uninsured populations. The vertical axis measures cost of care: the arrow to the right shows the true

[14] Traditional "major medical insurance" consisted of a list of covered services, a deductible, a co-insurance amount, and an out-of-pocket limit. Individuals with traditional insurance had an incentive not to solicit health care that was worth less to them than what they paid for it. Modern insurance contains features that are not true insurance, but rather are pre-paid care (see Section 7.2, "Essential Insurance"), which reduces users' personal out-of-pocket costs to zero. Overuse of medical services is wasteful. Studies of the effect of returning to traditional insurance products suggest that savings on the order of 5–15 percent of current expenditure levels are possible (RAND, 2005). Milton Friedman (Friedman, 1991) earlier had estimated that just two changes – moving to higher deductibles and eliminating the tax preference for employer-provided insurance – would lower national medical spending by 5 percent of GDP. Since national income devoted to personal health care expenditures is currently 14.5 percent of GDP, savings are potentially $0.15 \times 0.145 = 0.0217$, or 2.17 percent of GDP. Actual savings would be smaller because some plans already incorporate the beneficial effects discussed here.

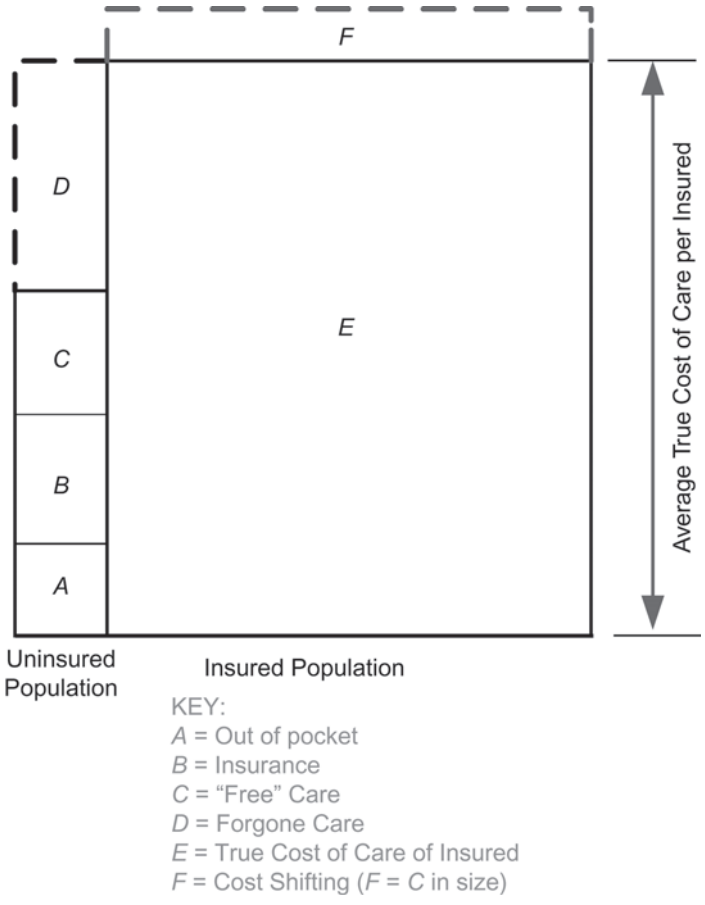

Figure 1.1. Pre-Program Costs and Embedded Cost Shifting

cost of care for an average insured individual. Area *E*, therefore, measures the health care costs of the insured population. The insured are currently charged for more than the true cost of their care because they are paying cost-shifting dollars (area *F* above area *E*) tacked onto the care they get. This money covers care given to the indigent, limited-pay, and no-pay consumers.

The size of the population of uninsured is displayed on the left of the diagram by the horizontal distance from the lower left corner. Areas *A* through *D* explain how the uninsured cover their care. Area *A* is usage by the uninsured paid through out-of-pocket expenditures by the uninsured, and area *B* represents care paid by insurance payments (Recall that roughly

half of the uninsured are uninsured for only part of the year)[15] and area *C* is "free care" that is paid for by cost shifting. Area *C*, therefore, equals area *F* in size. Area *D* is forgone care.

Figure 1.1 is not drawn to scale. Were it more detailed, we would separate the uninsured into full-year uninsured and part-year uninsured, and we would separate insured into the Medicare/Medicaid population and the privately insured population.

Returning to the figure, area *D* represents the "top-off costs" or forgone care of the uninsured. We draw area *D* as if the uninsured after becoming insured use the identical level of care per person as the insured do. As noted, they likely would use less because they are a statistically different population mix than the insured group, which includes Medicare and elderly patients.

The calculation of top-off costs *T* indicates that area *D* is roughly 1/2 to possibly slightly more than 1 percent of GDP. How is area *D* paid for in a well-designed framework? First, include incentives that cause the retention or enlargement of areas *A* and *B* because the uninsured include large numbers of people who can afford to purchase insurance and cover more of their own care. Second, include mechanisms that collect the money contained in area *F* and translate it into the program budget so that current cost-shifting dollars support the purchase of insurance by the fraction of the population that needs such aid. With the right framework, top-off costs will be all that is needed in addition to what the public is already paying. The TIP meets these requirements.

Figure 1.2 displays post-program finances. Both groups now have insurance and, as users and buyers of health care services, are indistinguishable to providers. The payment for care is also the same for both groups, meaning that everyone now pays for the true cost of his or her care plus a small uniform premium shown as area *H*. (More information about the rationale for the arrangements and its benefits is provided in Chapter 8, The Targeted Intervention Plan, and Appendix D, Plan Workability.) Rather than the sick paying cost-shifting dollars as in Figure 1.1, in the post-program world, the public cost of the program is spread proportionately to everyone.[16] The effective cost of care to the newly insured is not really area $A + G$ because a portion of area *G* is program aid for insurance purchase.

The program budget is met via a revenue tax that is nominally levied on all health care suppliers and providers. However, we hasten to note that because providers and insurers are free to set their prices, they naturally

[15] Hadley and Holahan, 2003, say 41 percent.

[16] Note that insurance premiums reflect insurance benefit outlays and thus each individual who buys insurance – that is, everyone – contributes to area *H*.

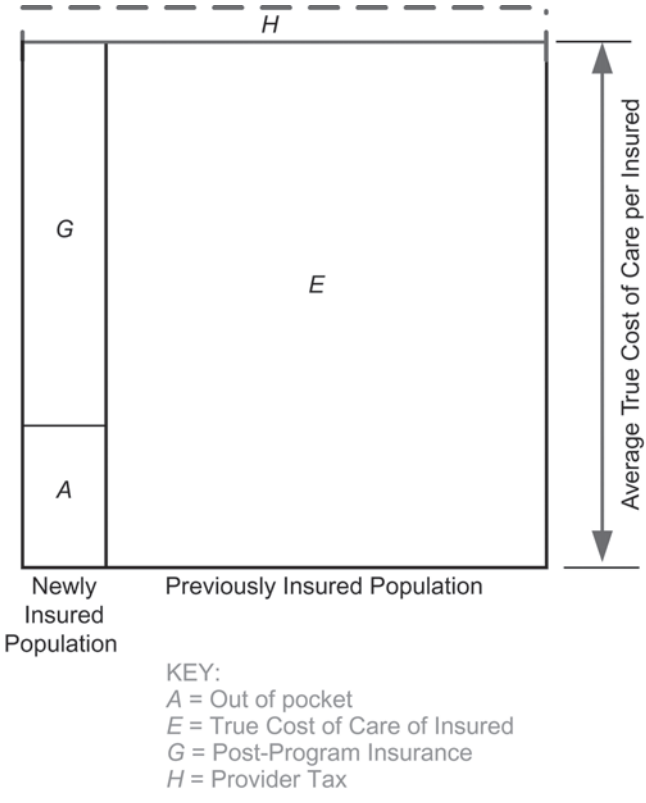

Figure 1.2. Post-Program Costs and Financing

pass on costs to consumers, who are the real payers in the form of higher prices. While we do not expect any tax to be popular a revenue tax is not an arbitrary choice and must be understood in context. The reasons are described in more detail in Chapter 8, "The Targeted Intervention Plan." However, we provide a few here, not least of which is that a revenue tax (1) treats all health care users (i.e., everyone) the same with respect to the elements of the program; (2) is appropriate because health care providers and insurers are recipients of public dollars through their sales to public aid recipients; (3) is needed to access cost-shifting dollars already in the system; and (4) is required to give government the ability to execute prior control over its net expenditures assigned to the program.

The goal is to pay for top-off costs in a fair manner; various details can be implementation choices. For example, should insurers be included in the base? To answer, presume care of $100 in equilibrium where a levy of